

the partial adhesion of the placenta, which, when detached, if the vital power is not too low, admits of retraction. Alteration of the structure of the placenta, as fibrinous or fatty degeneration, especially apt to occur in the previal flap, predisposes to self-detachment. The placenta may grow more rapidly than the seat of its attachment, and thus separation may take place. In the progress of many labors there is a stage when flooding is spontaneously arrested; this is due to contraction of the uterus and clot formation in the orifices of the vessels. The arrest of flooding is neither permanent nor secure until the whole of that portion of the placenta adhering to the lower zone is detached. The limit of dangerous attachment corresponds to the line before mentioned: below this the uterine segment must dilate to allow the passage of the child. Above it the uterus does not dilate. When the placenta is detached from this segment there is no physiological reason why further detachment or hemorrhage should take place until after the birth of the child. The portion which remains adherent is commonly sufficient to preserve the life of the child, and it is only in cases of central attachment or premature labor that its life is sacrificed. Adhesion over the os internum impedes the regular dilatation of the part. Injury and inflammation of the uterine structures, particularly of the cervix, are especially likely to ensue upon delivery in placenta previa. The greatest amount of hemorrhage frequently takes place at the commencement of labor, frequently before there is any clear indication of labor. The cervix is always, from its being near the seat of placental attachment, highly vascular, and is frequently very rigid; any attempt to force the hand through it, to detach the whole placenta or to deliver, must be made at the risk of injuring the womb. The dragging of the child through the cervix, even when it has not been necessary to introduce the hand into the uterus, is a proceeding of peril to both child and mother. It is desirable to expedite the stage of dilatation, avoiding violence. The arrest of flooding, and the expansion of the os may be promoted by rupturing the membranes and the use of tents. Since cross presentation or other unfavorable position of the child is apt to impede or destroy the regular contractions of the uterus which are necessary to arrest the flooding, it is mostly desirable to deliver as soon as the condition of the os will permit. In some cases rupture of the membranes and the employment of galvanism (?) may suffice to arrest the hemorrhage at the critical period when the total detachment of the placenta or forcible delivery is dangerous or impracticable, the introduction of the index finger through the os, and the forcible separation of the placenta from the dangerous zone, is a safe and practicable operation, and will convert the labor complicated by placenta previa into a normal labor. If the uterus does not assume the vigorous action neces-

sary to effect delivery, it will be necessary to dilate the cervix artificially. This can be readily done by the caoutchouc water dilator ("Barnes' bag"). Sufficient dilatation being obtained delivery may, if necessary, be accelerated by forceps turning or embryotomy, according to the special indications dictated by the condition of the child. In case of turning, he insists strenuously upon the importance of the delivery of the after-coming head by the forceps, if there be any difficulty or delay in the passage of the head under manual traction. He sums up the measures that come into successive use as follows: (1) Rupture of the membranes. (2) Apply a firm binder over the uterus. (3) A plug may be used to gain time, but it must not be trusted—watch closely. (4) Separate all the placenta that adheres within the lower zone, and observe closely. If no hemorrhage, wait awhile. The uterus may do its own work; if not dilate the cervix by the water bags. Again pause and observe. If Nature fails to deliver, resort to the forceps, which gives the best chance to the child, or turn. "In following this order of procedure, we strictly follow the law of physiology. We do not force Nature but obey her."—*British Medical Journal*, March 31, 1888.

NOTES ON THE TREATMENT OF ACUTE TONSILLITIS IN CHILDREN.

BY FRANK HAMILTON POTTER, M. D.,
Lecturer on Laryngology, Medical Department, Niagara University.

When an inflammation attacks the tonsil, it is influenced in its progress by those constitutional states that so markedly affect the natural history of disease. Hence, it is important to recognize the presence of syphilis, tuberculosis, rheumatism, etc., in the constitution of any patient we may be treating for a tonsillitis.

In children, these diseases may be latent, but none the less, they have a potent influence over the course of the malady under consideration. Therefore, we should always make ourselves familiar with the natural history of the parents, and, if any of these diseases are found, so modify our treatment as to meet and counteract whatever of baleful influence may have been transmitted to the child.

In the suggestions to follow, on the management of an acute tonsillitis in children, it must be understood that no routine practice is proposed. The plan detailed must be so modified as to meet the hereditary and acquired variations from health in the particular case under consideration.

In order to obtain a clear idea of what is required in a rational treatment of a tonsillitis, let us see how an inflammation may behave when attacking that organ. In our opinion, there has been too much refinement in this matter. Bearing in mind its anatomical structure, we observe, in the first place, that an inflammation may limit itself entirely to the tissue immediately surrounding the